times cut. There is very little danger of injury to the carotid. Rents in the pillars should be repaired immediately. Be sure to have the incision line (line of the anterior pillar) straight and clean and uniform on the two sides. The height of the incision should be alike on the two sides to have the best cosmetic result.

If you would avoid serious hemorrhage at all times, keep close to the capsule with your dissection. This will also avoid mutilation of the pillars with serious fatiguing adhesions and contractions of the pillars. Undue speed in operating results in hemorrhage and unsatisfactory results. Take your time. The primary incision is the most important and avoid passing through the capsule at this time. When the operation is finished, inspect both the tonsillar fossæ and the tonsils to see that no capsule or gland remains. This will insure favorable criticism when the throat is inspected by the next man who may be called upon to examine the case. It is most embarrassing to have it said that your work must have been that of an amateur.

Following the operation, the patient should be put to bed, without food or drink for at least twelve hours. He should be advised to keep as quiet as he can and not to attempt to clear the throat. An ice collar should be placed about the neck. The following day liquid may be given, and the following day, soft diet. The patient should gargle his throat frequently after the first day until complete healing takes place. As a rule the wounds will heal completely in from ten to fourteen days, in the absence of complications or constitutional disease. In case of mutilation of the pillars, healing will be very slow. In some cases the cervical glands will become infected, but rarely suppurate, and they do not, as a rule, require removal. In such cases, tonics, good food and fresh air will usually effect a cure. About the third day inspection often shows what appears to be a very bad looking wound, due to swelling in the plica triangularis, which is many times covered by follicles of lymphoid tissue. At the time of operation it is well to inspect this area and remove the lymphoid tissue, if necessary. Lung abscess occasionally occurs with local as well as general anesthesia. I know of no way to prevent this accident other than the most scrupulously clean operating. As a rule the voice is improved in strength and quality, and rarely suffers fatigue as the result of a well planned and carefully carried out technique.

In closing, a word should be said with regard to dealing with hemorrhage. Primary hemorrhage will rarely occur if the bleeding vessels are ligated with an anchored suture as described. Provided it cannot be controlled by the above method, a sponge may be sewn between the pillars, but should not be allowed to remain for more than thirty-six hours, for fear of sloughing and infection. Various sorts of tonsil clamps have been devised for control of severe hemorrhage, but they are painful when applied, and also produce sloughing when allowed to remain long in place. The usual treatment for severe hemorrhage has to be resorted to in rare cases—e. g., bandaging of the extremities, raising the foot of the bed, hypodermoclysis, Murphy drip and blood transfusion after typing. Morphine in full doses will relieve the extreme anxiety of the patient. Intravenous injection of iron cacodylate will serve well as a blood builder and tonic following hemorrhage, and assures the patient that you are doing something to speed up his convalescence and recovery.

INADEQUATE PERSONALITY WITH SPECIAL REFERENCE TO ITS INFLUENCE ON BOTH DIAGNOSIS AND TREATMENT*

By ROSS MOORE, M. D., Los Angeles.

Someone said or wrote, "There is nothing so real as the imagination." He meant the same thing the other sage did, who said, "Nothing ever exists except first in the imagination."

This paper does not deal with things of the imagination but does seek to make real a phase of diagnosis and therapeutics that is considered by many busy practitioners so unreal as to be almost imaginary. We are at a sort of turning point in the practice of the healing art. The profession is gradually realizing that the man whose eye is glued to the eyepiece of the microscope is not in the position of most usefulness to a suffering humanity.

It is a worthwhile task for the Neuropsychiatrist to help the profession in its efforts to practice good healing. This can best be done by insistence on that idea so well expressed in the last line of an old poem:

"'Tis not the body but the man is ill."

This means the study of personality in its relationship to disease.

My thesis is this: Symptoms and symptom complexes may be due not only to organic and functional causes, but also to what might be called temperamental causes. Surgeons naturally tend to believe in the organic basis of most symptoms. Frequently before and occasionally after operation they admit that seemingly organic symptoms may have had a functional basis. Physicians more readily agree that functional causes may be responsible for symptoms and symptom complexes that look decidedly organic. The daily experience of Neuropsychiatrists leads them to add "Temperament" to these other two sources of symptoms, thus completing an etiological trio in my opinion capable of including all disease manifestations. In psychiatry this etiological temperament is spoken of as "psychopathic personality." A more inclusive term to designate what I have in mind is, "inadequate personality." The word "inadequate" almost exactly expresses my concept of this personality. It is an etiological rather than pathological personality. It includes all types of personality likely to give rise to symptoms, but should not be applied to the feeble-minded.

If I succeed in elucidating my thesis by proving that temperament should be equally considered as a cause of disease alongside of the functional and organic causes, then a corollary appears; viz. that,

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whatever symptomatology is actually due to the inadequate temperament must be considered as being permanent.

Temperament is just as inborn and fixed as the color of one's eyes or the length of one's nose. Symptoms due to temperament should not be called symptoms, but characteristics.

This paper is written to call attention to some of the types of inadequate personality, so that the therapy of general practice may be directed away from an effort to cure characteristics. These characteristics are to be brought to the attention of the patient in their true form so that he may adjust himself to considering them as permanent handicaps, and therefore not be irritated by their presence but rather learn to ignore them in his program through life.

Speaking generally, the personality of an individual may be inadequate in four ways: (1) physical, (2) neural, (3) moral, (4) emotional. A given individual may exhibit one or a combination of these types.

The psysical type of the inadequate exhibits in his physical makeup an unbalance so extensive as to make him unfit to cope with physical emergencies. He may be small and slight of build or tall and very slender. He frequently has abnormally small hands and feet, as if nature realized the sorry joke she was perpetrating when she allowed the individual to be born, and tried thus to mark him a parasite and not a worker. This physical type has been quite well recognized for a long time. He is, therefore, less misunderstood by his hurrying fellow humans, and his busy physicians. Physical inadequacy is found associated with neural and emotional inadequacy very frequently. Probably less frequent with moral.

The neural inadequate turned up frequently in the work of the neuropsychiatrist in the army both in this country and France. I personally came to the conclusion that he was the one particular type of the inadequate whom I felt must be kept from front line service. He is usually bright, smart and active both mentally and physically, but with little reserve. He is parallel in his neural makeup to the person whose mind or intellect is characterized by the term "shallow." Superficial observation would not lead to the detection of his actual inadequacy, because he learns to camouflage it by a show of transient vigor, much as the shallow intellect can cover itself by a temporary show of brilliancy.

The moral inadequate is the individual who stopped his human or civilized development at the period in life when it is said that a child is inherently cruel. He has modified his outlook on life only as much as is necessary to keep him from getting into uncomfortable situations. He cannot sense what is meant by altruism. He is a curious combination of thoughtless impulsiveness with carelessness of consequences.

The emotional inadequate is very difficult to describe. He is not necessarily emotionally unstable and may even appear emotionally barren. His type merges quite insensibly into that of the repressed individual—the unfortunate who has had emotional sterility thrust upon him. Indeed it is quite to be expected that the emotional inadequate will come of repressed parentage and, therefore, will be both temperamentally and developmentally inadequate. The experiences of life will have more influence on this person than on any of the other types of inadequacy. Whereas the neural inadequate will usually react very quickly to his surroundings, the emotional type may do the same or apparently not react at all. Nevertheless, his emotional reaction to his experiences and his suroundings is going on deep within him and inexorably produces a pathological personality later on because of that immobility which is inborn.

I have suggested these four types for purposes of description. They seldom exist in pure form. Whether they are pure or all mixed together in a given case is quite immaterial, providing it is recognized that they actually do exist. Inherent or inborn inadequacy being established, it remains for the therapist to manage his patient, his patient's friends, and the general surroundings and conditions so that these characteristics of inadequacy are adjusted for rather than an attempt made to remove them. The above presentation is totally incomplete and is designed simply to be suggestive.

CASE REPORT

A case in point. Unmarried girl, twenty-two. Physically small. Small unused hands. Father, a quiet, reserved successful business man, who knows how to work, but not how to play. Mother physically inadequate and repressed. Patient developed cardiac lesion at twelve years of age. Has been an invalid ever since. Dabbled a little in art, and has read widely in field of romance. Has very good taste, uses good English, and is very pretty and attractive. Considers herself a hopeless invalid and, therefore, has no outlook on the future. Romances about life and marriage, but does not look upon any young man as attainable in the way of a husband for herself.

Here is a combination of physical, emotional and neural inadequacy, with the added handicap of maternal repression and insistence on the fact of invalidism.

It was determined that the cardiac condition was negligible. It remained to determine how much of the residual symptomatology was temperamental and permanent, and how much was due to maternal inadequacy and the inevitable introspection of the shut-in. Some months of therapeutic effort sufficed to clear up most of the symptomatology due to these latter causes. The result was that the patient began to fearlessly ask questions about life and sex, and self; began to think and act for herself; began to make a place for herself in society; began to attract the young men—in short, is approaching a condition that should be considered normal for her. She had gone along for several years having medicine given her for her heart, being curetted, being sanitariumed, and being invalided, because an effort was being made to correct the whole clinical picture.

If this concept of inadequacy had been in the minds of her physicians, they would have made this differentiation between removable and irremovable symptoms; would have cleared up the former,

and helped the patient to adjust her life so that the latter would be the least possible handicap.

CONCLUSIONS

1. There is such a thing as inadequate personality.

2. It is congenital and irrecoverable.

3. It manifests itself in the physical, neural, moral, and emotional parts of human nature.

4. It gives rise to symptoms which may simulate closely those of organic or functional disease and which may be mistaken for evidence of the latter.

5. It is usually associated with acquired illness.

6. When it is so associated all therapeutic effort aimed at relieving symptoms caused by it will end in disaster.

7. When its presence is recognized and taken into therapeutic consideration much improvement can be brought about in the patient.

8. Its presence will be determined by careful consideration of the history of the patient rather than by examination.

9. The history necessary for diagnosis does not relate to previous illnesses sustained, but to the reaction of the patient to his environment and all data capable of giving a true estimate of that intangible thing called personality.

THE SPECIALIST AND HIS OBLIGATION TO THE PROFESSION *

* Chairman's address before Urological Section,

By GEORGE G. REINLE, M. D., Oakland

As members of the medical profession we hold an unusual position in the social structure and we have an obligation to render our best service to the public. We stand in the generally accepted position of mentors and advisors in matters pertaining to health. Less generally recognized, however, and of much the same character, is the obligation of the specialist to the balance of the medical profession. As the public has conferred upon the whole profession certain privileges and exemptions which must be repaid by a special regard, so has the profession permitted the specialist certain exemptions and is, in return, entitled to even greater considerations.

I should like at this time to call your attention to some of those things about which you have all thought, and upon which you all entertain well-developed ideas, which, unfortunately, you either keep to yourselves or express only in private. I have reference to those obligations which the specialist owes to the profession, and, conversely, what the specialist should expect from the profession in general.

Specialists are prone to be critical in their views, and intemperate in the expression of their opinions, concerning the character of the work accomplished by men doing both general medicine and general surgery. Not infrequently we hear complaint that cases which drift to the specialist have been treated overlong and inappropriately by those unprepared to render the proper service. This fault applies to specialists in every line. The oculist inveighs against the neglected case of tracoma which has lapsed into hopelessness, and he also has other things to which he takes exception, more or less privately, or to lay friends. The aurist bewails the palliative treatment of running ears, which come to him as acute mastoiditis. The urologist finds fault with infected kidneys, tubercular and otherwise, which have been treated by useless bladder irrigations, urotropin and probably vaccines. The urologist also has numerous other faults to find with the management of patients whom he feels should have been treated differently or correctly diagnosed at an earlier date.

These fault-findings are not entirely just. If the patients whom a specialist should have seen, either in consultation or directly, are not brought to his attention at the preferred time, the fault lies with the specialist himself, and should feel rather acutely that he has been remiss in one of the principal debts he owes to the profession. The specialist has neglected to convey to his colleagues the cardinal indications for consultation. It may be argued that the indications are well known, that text books point out where specialized skill or knowledge should be made available. This plea is insufficient. One needs but to recall the fact that the volume of medical literature is very great, that the important is so closely interwoven with the relatively less important that not infrequently only the specialist himself can say what is vital and what is not.

What is needed is that the specialist be a propagandist—a special pleader—not for himself, nor his profession, but for humanity. Most of the writings of medical men are addressed to the group doing the same type of work as themselves. What is needed is that the specialist address himself to the profession, writing and speaking, not about the unusual, but about such commonplaces as stone in the bladder, stone in the kidney and tubercular kidney. His literature, addressed to the profession at large, should be instructive, warning of the dangers possibly lying back of a frequency of urination, of certain microscopic urinary findings, and so forth.

These articles should indulge in plain speaking. No harm can be done, and good will result from articles couched in terms of humanity, rather than in the somewhat less startling terms of science.

There are many reasons why men in general practice treat patients which in their very nature require special skill, and most of these reasons are not selfish. Consider that nearly every individual or family has an acquaintance with some medical man. The patient presents himself with frequency, because of pyurea or some other urological symptom. The matter may not be looked upon by the patient as being of particular importance. The physician, untrained in the significance of the symptoms, and through years of experience having reached the conclusion that the majority of human ailments are transitory anyway, hopes for a passing of the trouble, resorts to some innoxious palliative treatment. The patient who does not realize the difference between the significant and the trivial may insist upon con-

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